Billing 4

LTCH PPS Billing

LTCH PPS billing considerations

Objective

This chapter addresses the many important billing aspects of the new Long-Term Care Hospital prospective payment system.

Participants will learn about the following information in the course of this chapter:

The LTCH PPS billing implementation effective date.

Medicare billing requirements not affected by LTCH PPS.

New Medicare billing requirements for LTCH PPS.

Medicare billing requirements for claims within the transition period to LTCH PPS.

Medicare billing requirements for PPS providers with which LTCHs may not be familiar.

LTCH PPS Implementation Schedule

LTCH PPS is effective on the first day of the LTCH's cost reporting period that begins on or after October 1, 2002. LTCHs will transition to the LTCH PPS on the first day of their cost reporting period that begins on or after October 1, 2002. See Table 4.1 for examples of LTCH PPS effective dates.

Table 4.1 Examples of LTCH PPS Effective Dates

Cost Report Period Start Date	LTCH PPS Effective Date
October 1, 2002	October 1, 2002
January 1, 2003	January 1, 2003
April 1, 2003	April 1, 2003
July 1, 2003	July 1, 2003

Guidelines for billing Medicare under LTCH PPS are applicable to Medicare Part A fee-for-service long-term care services and effective for discharges beginning on or after the LTCH's cost reporting period that begins on or after October 1, 2002.

Under the fully implemented LTCH PPS, Medicare will pay each LTCH discharge from an LTCH based upon the LTC-DRG to which it is assigned.

LTCH provider's claims will be payable under the policies of the LTCH Prospective Payment System on the first day of that provider's cost reporting period that begins on or after October 1, 2002.

Standard Systems Delay

Unfortunately, the standard processing systems will not have the necessary computer system changes in place to fully accommodate claims processing and payment under the LTCH Prospective Payment System until after January 1, 2003. Therefore, although claims by LTCHs will be payable under the LTCH PPS following October 1, 2002, actual payments during the interim will be made using the pre-existing procedures.

However, beginning October 16, 2002, all LTCHs will be required to comply with the HIPAA Administrative Simplification Standards, unless they have obtained an extension in compliance with the Administrative Compliance Act. This requirement means LTCHs must submit claims in compliance with the standards at 42 CFR

162.1002 and 45 CFR 162.1192 and use the ICD-9-CM coding. All ICD-9-CM coding must be used by LTCH providers with cost reporting period beginning on or after October 1, 2002.

After the standard systems are updated, the Medicare payments made to LTCHs from cost reporting periods that began on or after October 1, 2002 will be reconciled based on the LTCH prospective payment methodology.

LTCHs are not required to hold the submission of claims to Medicare until the standard processing systems are ready. It is essential that, when submitting claims, LTCHs utilize LTCH PPS billing guidelines and correct coding techniques for any discharges payable under the LTCH PPS. In other words, each LTCH should use the new guidelines and coding as soon as the LTCH PPS is effective for that provider, regardless of whether the standard systems are ready.

Billing Requirements Unchanged by the Implementation of LTCH PPS

Once an LTCH has transitioned to the LTCH PPS, it should bill Medicare in accordance with the new LTCH PPS billing instructions and with the existing applicable Medicare billing instructions for Acute Care Hospital PPS (also known as Inpatient PPS) providers.

However, many of the requirements for hospitals excluded from inpatient PPS, under which LTCHs were billing, are the same as the acute care hospital PPS billing requirements and will therefore not be changed as a result of the implementation of the LTCH PPS.

FI and CWF Processing

Claims must be submitted to the FI for processing and will be subject to various claims processing edits. Once processed by the FI, claims will be sent to the Common Working File (CWF) for additional editing and posting in the beneficiary's national Medicare record.

Timely Filing

Claims must be submitted to the FI in a timely manner. For dates of service January 1 to September 30, the timely filing limit is December 31 of the following year. For dates of service October 1 to December 31, the timely filing limit is December 31 of the second year following the date of service.

Examples:

If the date of service is between January 1, 2002 and September 30, 2002, the claim must be submitted to the FI by December 31, 2003

If the date of service is between October 1, 2002 and December 31, 2002, the claim must be submitted to the FI by December 31, 2004

Bill Types and Claim Change Reason Codes

LTCH inpatient claims should be submitted on a "11X" type of bill. Please note that types of bill 113, 114, and 115 will no longer be appropriate for LTCHs to use. A 117 type of bill is used for adjustments, while a 118 type of bill is used for cancels. Claim adjustments and cancels can be submitted using established guidelines.

The "Claim Change Reason Codes" are listed on the next page. Providers should submit one code with each adjustment or cancel request. If multiple requests are necessary, the provider should choose the single reason that best describes the request. The code "D1" should be used only when the charges are the only change on the claim. Other claim change reasons frequently also change charges, but providers should not "add" reason code "D1" when this occurs.

Table 4.2 Claim Change Reason Codes

Bill Type	Reason Code	Explanation
xx7	D0 (zero)	Change to service dates
xx7	D1	Change in charges
xx7	D2	Change in revenue codes/HCPCS
xx7	D3	Second or subsequent interim PPS bill
xx7	D4	Change in GROUPER input (diagnoses or procedures)
xx8	D5	Cancel-only to correct a HICN or provider identification number
xx8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.
xx7	D7	Change to make Medicare the secondary payer
xx7	D8	Change to make Medicare the primary payer
xx7	D9	Any other change
xx7	E0 (zero)	Change in patient status

General Coding

LTCHs will submit claims according to Section 3604 of the Medicare Intermediary Manual. Claims are to be prepared using established guidelines for general coding. This includes, but is not limited to the guidelines for ancillary services, leaves of absence and Medicare Secondary Payer (MSP) billing.

Patient Status Codes

Although the implementation of LTCH PPS does not include the development of new patient status codes, you may find it helpful to review the three patient status (discharge status) codes have been added to the existing inpatient patient status codes in the last two years.

Program Memorandum A-01-86, published July 24, 2001, introduced two new patient status codes to indicate when a patient is discharged to another inpatient rehabilitation facility (patient status 62) or a long-term care hospital (patient status 63). These new patient status codes were effective as of January 1, 2002.

Program Memorandum A-02-022 published March 22, 2002 clarified Program Memorandum A-01-86. The word "another" was removed from the definition of patient status code 62. The definition currently indicates that a patient is discharged/transferred to an inpatient rehabilitation facility (IRF).

Program Memorandum A-02-041 published May 17, 2002 introduced a new patient status code to indicate when a patient is discharged/transferred to a Skilled Nursing Facility (SNF) certified under Medicaid but not certified under Medicare (patient status 64). This new patient status code will be effective for discharges on or after October 1, 2002.

It is important that providers indicate the appropriate patient status code when billing Medicare. However, under LTCH PPS, there are no special payment policies for transfer cases, other than for interrupted stays.

Patient Status Codes and Definitions

Table 4.3 Patient Status Codes

PSC	Definition
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF (For hospitals with an approved swing-bed arrangement, use Code 61-Swing-bed
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharge/transferred to home under care of a home IV drug therapy provider
20	Expired (or did not recover - Christian Science Patient)
30	Still a patient
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing-bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF)
63	Discharged/transferred to a long-term care hospital (LTCH)
64	Discharged to a Skilled Nursing Facility (SNF) certified under Medicaid but not certified under Medicare

Ancillary Services

Payment may be made under Part B for certain services when furnished by a participating LTCH to an inpatient of that hospital when payment for these services cannot be made under Medicare Part A. The billing rules for ancillary services continue to apply under LTCH PPS.

When coding LTCH PPS bills for ancillary services associated with a Part A inpatient stay, the bill type is 12X and the traditional revenue codes will continue to be shown in conjunction with the appropriate entries in the Service Units, and Total Charges fields. LTCH providers should also:

Report the number of units based on the procedure or service

Report the actual charge for each line item in Total Charges

Report the date of service for each line item ("line item date of service") with appropriate HCPCS coding

Reference:

For a complete list of medical items and other services that can be billed under this provision or for more information concerning covered ancillaries, providers may refer to the CMS Hospital Manual, Pub.10 Sections 228 and 431 or Pub.13 Section 3626.1.

Pre-Admission Services

The Medicare billing rule for pre-admission services remains the same for LTCHs under LTCH PPS as it was under the prior payment method. LTCHs remain subject to the Medicare billing rule for pre-admission services that fall within 24 hours prior to the beneficiary's admission. Although LTCHs will now be paid under a prospective payment method, they should not utilize the 72-hour rule for pre-admission services that inpatient acute care PPS providers do. LTCHs may refer to the CMS Hospital Manual, Pub.10, Section 415.6 or Pub. 13, Section 3610.3 for additional information on this subject.

Adapting Existing IPPS Requirements for LTCH PPS Billing

Prior to the implementation of the LTCH PPS, LTCHs billed using the requirements for hospitals excluded from the inpatient PPS. As previously mentioned, once an LTCH has transitioned to the LTCH PPS, it should bill Medicare in accordance with the new LTCH-specific billing instructions and existing applicable Medicare billing instructions for Acute Care Hospital PPS providers. This will result in a change in Medicare billing requirements for LTCHs.

One new major factor for LTCHs to consider, especially when applying the billing guidelines from the Acute Care Hospital PPS to claims billed under LTCH PPS is the impact benefit utilization has on payment.

Under the Acute Care Hospital PPS, the basic prospective payment amount is paid to the provider if the beneficiary has at least one benefit day remaining at the time of admission.

However, under the LTCH PPS, Medicare will pay an LTCH a full LTC-DRG if a patient has sufficient Medicare benefit days to exceed the number of days that would categorize the case as a short-stay outlier (i.e., greater than 5/6 of the ALOS for the particular LTC-DRG assigned).

A short stay outlier payment is generated when the patient has benefit days to exceed the short stay outlier threshold, but the stay itself does not exceed the short stay outlier criteria.

If a patient does not have sufficient Medicare benefit days to exceed the number of days that would categorize the case as a short-stay outlier (i.e., equal to or less than 5/6 of the ALOS for the particular LTC-DRG assigned), then a short-stay outlier payment is generated.

This is different than the TEFRA reasonable cost payment system that LTCHs previously used. It is also different than the Acute Care Hospital PPS. This difference impacts the way, in which some claims must be coded, particularly claims impacted by an exhaustion of benefits and high cost outliers, which will be reviewed later.

The examples on the next few pages should help illustrate the availability of benefits and its relationship to the payment of the claim.

Lifetime Reserve (LTR) Days – Policy for Use

Before looking at each example, the policy regarding the use of lifetime reserve (LTR) days in the LTCH PPS must be clear.

If a beneficiary did not have enough regular Medicare days to exceed the short stay outlier threshold, the beneficiary could use his/her LTR days to exceed the short stay outlier threshold so that a full LTC-DRG payment could be generated. However, under LTCH PPS, once a beneficiary starts using LTR days, they must continue to use them for each remaining day of hospitalization for that episode of care, even if no additional Medicare payments are generated, until any applicable high cost outlier threshold is reached.

The beneficiary continues to maintain the right to elect not to use the LTR days to either exceed the short stay outlier threshold or within the high cost outlier period. However, the choice not to use the LTR days would result in beneficiary liability. If the beneficiary elects to use LTR days, the days must continue to be used until the patient is discharged.

Benefit Availability and Full LTC-DRG Payment

Remember that under LTCH PPS, Medicare will pay a full LTC-DRG payment when the length of stay **exceeds** the short stay outlier criteria (5/6 of the ALOS for the assigned LTC-DRG) **and** the patient has benefits available for each day up to this point.

It is also important to note that as soon as the patient's stay exceeds the short stay outlier criteria, the full LTC-DRG **is** applicable.

Please Note:

In each of the following examples, it is assumed that the patient **does** elect to use any available LTR days and that each case is **not** a high cost outlier situation.

Example–Full LTC-DRG Paid

Patient is admitted to the LTCH on 11/01/02 and discharged on 11/30/02 for a total stay of 29 days.

The average length of stay (ALOS) for the assigned LTC-DRG is 12 days and 5/6 of this is 10 days.

At admission, the patient has 15 coinsurance days and 3 LTR days.

The case is payable at full LTC-DRG **because the length of stay exceeds the short stay outlier threshold (29 days > 10 days) and the patient has enough benefits to exceed the short stay outlier criteria** (18 days > 10 days).

Benefit Availability and Short Stay Outlier Payment

Remember that under LTCH PPS, Medicare will pay a short-stay outlier payment when the length of stay is equal to or less the short stay outlier threshold. This may occur if the patient is discharged or dies before the length of stay exceeds the short stay outlier criteria. The short stay outlier payment is made with respect to the number of days for which the beneficiary had benefits available. The first short stay outlier example reflects this situation:

Short Stay Outlier Payment: Example #1

Patient admitted to LTCH on 10/10/02 and discharged on 10/19/02 for a total stay of 9 days.

The ALOS for the assigned LTC-DRG is 12 days and 5/6 of this is 10 days.

At admission, the patient has 20 coinsurance and 0 LTR days available.

The case is **payable as a short stay outlier** (even though the patient has enough benefit days to cover the entire stay) **because the entire stay does not exceed the ALOS** for the LTC-DRG (9 days < 10 days). The short stay outlier payment will be made with respect to 9 days.

Remember that Medicare will pay a short stay outlier when the length of stay exceeds the short stay outlier threshold for the assigned LTC, but the patient has only enough benefits available to cover up to and including the short stay outlier threshold for the assigned LTC-DRG. This may occur if the patient exhausts Medicare benefits before the length of stay exceeds the short stay outlier criteria. The short stay outlier payment is made with respect to the number of days for which the beneficiary had benefits available. The second short stay outlier example reflects this situation:

Short Stay Outlier Payment: Example #2

Patient is admitted to the LTCH on 10/10/02 and discharged on 10/30/02 for a total stay of 20 days.

The ALOS for the assigned LTC-DRG is 12 days and 5/6 of this is 10 days.

At admission, the patient has 3 coinsurance days and 7 LTR days.

The case is payable as a short stay outlier because the patient does not have enough benefits available to the short stay outlier threshold for the assigned LTC-DRG (10 days = 10 days). The short stay outlier payment will be made with respect to 10 days.

It is important to remember that under the short stay outlier policy providers are paid the least of the three calculations described in the Payment Section of this Training Guide. **That is, Medicare will pay the lesser of 120% of a per diem payment calculated for that LTC-DRG, 120% of the cost of the case, or the full LTC-DRG.**

The policy underlying this formula is that the payment increases as the length of stay approaches the average length of stay for the LTC-DRG. When the payment made under the short stay outlier policy (the lowest of the three payment options) is 120% of the LTC-DRG per diem and the patient's length of stay is exactly equal to 5/6 of the average length of stay of the LTC-DRG, the short stay outlier payment will actually be the full LTC-DRG payment, which would be the lowest of the three payment options.

Therefore, in this example, we would compute the payment under the short stay policy because the day count did not exceed the average length of stay for the LTC-DRG, but in effect, for this case, Medicare would pay the full LTC-DRG.

This example proves that the mathematical logic underlying the short stay outlier policy has considerable legitimacy.

If the situation were the same but, at admission, the patient has three coinsurance and one LTR day, the case would be payable as a short stay outlier because the patient does not have enough benefits available to exceed the short stay outlier threshold for the assigned LTC-DRG (4 days < 10 days) and the short stay outlier payment will be made with respect to four days.

At admission, these patients would have to have at least 11 benefit days available for the case to exceed the short stay outlier threshold and be payable at a full LTC-DRG (11 days > 10 days).

Table 4.4 outlines the above examples plus several additional scenarios.

ALOS of LTC-DRG	*Short Stay Outlier Threshold (5/6 of ALOS)*	*Actual Length of Stay*	*Payable as Short Stay Outlier*	*Benefit Days Available (Full/ Co/LTR)*	*LTR Used Assuming patient elects to use if needed.*	*Medicare-Payable Days*
12	10	29	No	0/15/3	0	29
12	10	9	Yes	0/20/0	0	9
12	10	20	Yes	0/3/7	7	10
12	10	20	Yes	0/3/1	1	4
12	10	20	No	0/9/2	2	20
30	25	25	Yes	0/15/30	10	25
30	25	20	Yes	0/15/30	5	20
30	25	27	No	0/15/30	12	27
30	25	29	No	0/25/30	4	29
30 Beneficiary "A"-Chapter 2	25	35	No	0/26/30	0	35
30	25	45	No	0/26/30	0	45
30 Beneficiary "B"-Chapter 2	25	35	No	0/10/30	25	35

New Billing Requirements Under LTCH PPS

The following subjects relate to billing requirements and concepts that, under LTCH PPS, are new to the LTCH. These subjects include new billing instructions from the LTCH PPS Final Rule as well as the requirements from the CMS Manual, Pub.10 for PPS providers subject to a PPS.

One Claim Per Stay

After the implementation of the LTCH PPS, only one claim will represent an entire inpatient stay. The following topics provide an explanation of this new billing concept for LTCHs.

Interim Billing

Providers under periodic interim payments (PIP) are **not** allowed to submit interim bills under LTCH PPS.

Providers that are **not** under PIP and are experiencing unusually long stays **are** permitted to submit interim bills.

These non-PIP providers may bill for the 60 days after an admission and every 60 days thereafter.

Sequential billing, using types of bills 113 and 114, is not allowed under the LTCH PPS.

The first 60-day interim bill should be submitted to Medicare using a 112 type of bill. The non-PIP LTCH may submit subsequent changes to the 112 type of bill by using type of bill 117 (adjustment) with claim change reason code D3.

Late Charge Billing

Late charge claims (type of bill 115) are **not** permitted under LTCH PPS. If a provider has late charges to add to a claim that has been processed by Medicare, an adjustment bill (type of bill 117) must be submitted.

Split Billing

Payment under LTCH PPS is based on discharge. As a result, split billing is no longer required when claims cross a provider's PPS effective date, fiscal year, or the CMS fiscal year (October 1st).

Claims Crossing the LTCH PPS Transition Date

The elimination of split billing also means that claims for services that cross over the date of transition to the new prospective payment system are allowed because payment under LTCH PPS is based on the discharge date.

Note:

It is important that claims crossing the LTCH's implementation date for LTCH PPS be coded using the new LTCH PPS requirements.

Patients Who Are Currently Inpatients When Transition to PPS Occurs

Although claims for services that cross over the date of transition are allowed, it is possible that an LTCH may have submitted interim claim(s) for beneficiaries who were admitted before the transition to LTCH PPS, but discharged after it.

Therefore, before submitting a new claim to Medicare for such patients, **the LTCH should first review its Medicare claim submission history**.

If no interim bills have been submitted prior to the implementation of LTCH PPS, the provider should submit one bill, from admission through discharge for discharges occurring after the implementation of LTCH PPS. No special coding, other than LTCH PPS coding, is required on a claim that crosses over the facility's transition date.

If an interim bill or multiple interim bills have been submitted prior to the implementation of LTCH PPS, but the beneficiary is discharged after the implementation of PPS, the LTCH should follow the guidelines below:

One Interim Claim Previously Submitted

If only one interim claim had previously been submitted to Medicare and processed for a patient who is being discharged after the implementation of LTCH PPS, the claim must bill adjusted using a 117 type of bill (adjustment) to add services through discharge using the appropriate LTCH PPS coding.

Multiple Interim Claims Previously Submitted

If multiple interim claims had previously been submitted to Medicare and processed for a patient who is being discharged after the implementation of LTCH PPS, all such interim claims must be cancelled using a 118 type of bill (cancel). After all of the cancellations of the interim claims have been finalized, one new claim must be submitted from admission through discharge using the appropriate LTCH PPS coding. Or, all of the 113 types of bills must first be cancelled. After all of the cancellations have been finalized, an adjustment to the 112 type of bill can be submitted to add services through discharge using the appropriate LTCH PPS coding.

Disclaimer for Providers Who Transition to PPS Between October 1, 2002 and January 1, 2003

For LTCH providers with PPS transition dates prior to the implementation of the systems changes scheduled on or about January 1, 2003, the above sections on "Split Billing," "Claims Crossing at he LTCH PPS Transition Dates," and "Patients Who Are Currently Inpatients When Transition to PPS Occur" have the following applicable changes:

Currently, there are edits in place that prohibit the submission of claims that span an LTCH's fiscal year start date. These edits require the hospital to split the bill over the cost report begin date. Until LTCH PPS systems changes are in place, LTCHs must continue to split their bills if there are patients in the LTCH when the LTCH transitions over to PPS in order to receive payment. Once the changes are implemented, pre-PPS bills must be cancelled and the entire stay should be re-billed using the PPS guidelines explained in the aforementioned sections

Interrupted Stays

Another situation within the "one claim for the entire stay" concept is the interrupted stay.

Interrupted stays are those cases in which a Medicare beneficiary is discharged from the LTCH and admitted to an acute care hospital, an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF) including Swing-beds and returns to the same LTCH within a fixed day period.

Under LTCH PPS, **one claim should be submitted** when there has been an interrupted stay. An interrupted stay case is treated as one discharge for the purposes of payment; only one LTCH PPS payment is made.

Fixed-Day Periods

The fixed-day period during which the Medicare beneficiary must return to the LTCH differs for each facility type within the interrupted stay policy. Each fixed day period of time is dependent upon the facility type to which the patient is being admitted to upon discharge from the LTCH.

For a discharge to an acute care hospital, the applicable fixed day period is 9 days or less.

For a discharge to an IRF, the applicable fixed day period is 27 days or less.

For a discharge to a SNF or Swing-bed, the applicable fixed day period is 45 days or less.

The counting of the days begins on the day of discharge from the LTCH and ends on either the 9th day, 27th day or 45th day after the discharge depending on the facility type.

Interrupted Stay: Example #1-A

If a patient is admitted to an LTCH on 10/05/02 and is discharged from the LTCH and admitted to an acute care hospital on 10/10/02, the day count of the interruption begins on 10/10/02. To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the ninth day after discharge, which is on or before 10/18/02.

Interrupted Stay: Example #2-A

A patient is admitted to an LTCH on 10/05/02. The patient is discharged from the LTCH and admitted to an IRF on 11/30/02. The day count of the interruption begins on 11/30/02. To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the 27th day after discharge, which is on or before 12/26/02.

Interrupted Stay: Example #3-A

If a patient is admitted to an LTCH on 10/05/02 and is then discharged from the LTCH and admitted to a SNF or Swing-bed on 10/10/02, the day count of the interruption begins on 10/10/02. To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the 45th day after discharge, which is on or before 11/23/02.

If the length of stay at the receiving site of care falls within the above-listed fixed periods of time, then the original stay and the second LTCH stay would be billed to Medicare on **one** claim. This claim must also reflect the period of time (interrupted stay) that the patient spent at the receiving site of care.

Multiple Interrupted Stays

Multiple interrupted stays should be entered as one claim but each interrupted stay should be evaluated individually for the rule regarding the appropriate number of days at the intervening facility.

Situations That Are Not Interrupted Stays

There are three "discharge then readmission" situations that do not meet the definition of an interrupted stay under LTCH PPS:

1. If the length of stay at the "receiving" site of care exceeds the above-listed fixed periods of time, then the return to the LTCH will be a new admission.

2. If the "receiving" site of care is not an acute care hospital, an IRF, Swing-bed or a SNF, the return to the LTCH will be a new admission.

3. If the patient is admitted to more than one facility before returning to the LTCH, or goes home between LTCH stays, the return to the LTCH will be a new admission.

In all of these situations, this means that the original stay at the LTCH will be treated as a discharge for payment purposes and the new admission through discharge will also be treated as a discharge for payment purposes; therefore, two separate payments will be made to the LTCH.

LTCH Length of Stay Determines Payment Policy

The total number of covered days of a patient's length of stay in an LTCH prior to and following the interrupted stay determine the LTCH PPS payment policy that applies to the claim. The first date of discharge is counted as an interruption day. The date of the return to the LTCH is a benefit day and counts toward utilization. The second date if discharge, consistent with existing regulations, is not payable and does not count toward utilization.

Payment is determined at final discharge. Medicare would pay for the episode of care at the LTCH as a short-stay outlier or a full LTC-DRG payment based on the length of stay. **Such a stay could also result in high cost outlier payments.**

Likewise, the number of days that the beneficiary is a patient at the other facility during an LTCH interrupted stay, would not be included in determining the length of stay at the LTCH. The receiving site of the interrupted stay is payable under its respective payment method for the time the patient spends in that facility.

Submitting Interrupted Stay Claims to Medicare

An LTCH **may, but is not required to**, hold the submission of a claim to Medicare. **Or**, if an LTCH discharges a patient and then the patient is admitted to one of these facility types, the LTCH may submit the claim to Medicare for services from the initial admission through the second date of discharge.

If a patient returns to the LTCH within the fixed period of time from the acute care hospital, the IRF or the SNF (including swing-beds), the provider would need to review the Medicare claim submission history for each patient for the following.

1. If the LTCH had not already submitted a claim for the original stay to Medicare, then the provider would bill the entire stay on one claim, including the original stay and the second LTCH stay.

2. If the LTCH had already submitted a claim for the original stay to Medicare, the original claim would need to be adjusted using claim change reason code D0 to add the second LTCH stay.

3. If an LTCH mistakenly submitted two separate claims that should have been billed as one claim, the claim for the second stay will need to be cancelled using claim change reason code D6. The claim for the original stay will need to be adjusted using claim change reason code D0 to add the second LTCH.

In each of these cases, the final admission through discharge claim must also reflect the period of time at the "receiving" provider, but not the respective services and charges of that provider. We will discuss the ways in which these days/dates are reflected on the claim next.

Once the standard systems are updated to accommodate LTCH PPS claims processing and payment, Common Working File (CWF) will edit claims that should have been billed as interrupted stays but were not. It will also edit claims that are billed as interrupted stays, but should not have been.

Occurrence Span Code 74 and Accommodation Revenue Code 018X

Note: The definitions and use of the 74 occurrence span code and the 018X revenue code are different from the definition of the interrupted stay.

On the UB-92 claim, the interrupted days are represented with an occurrence span code 74 and an accommodation revenue code of 018X. Providers should continue to use the occurrence span code 74 and the accommodation revenue code 018X in the current manner.

The occurrence span code 74 would reflect the "span code from date" equal to the date of discharge from the LTCH and the "span code through date" equal to the last day the patient was not present at midnight.

The 018X revenue code would reflect the number of days represented within the 74 occurrence span code.

Example #1-B:

In Example #1-A above, the occurrence span code 74 would show a from date of 10/10/02 and a through date of 10/17/02. The 018X revenue code would reflect 8 units.

Example #2-B:

In Example #2A above, the occurrence span code 74 would show a from date of 11/30/02 and a through date of 12/25/02. The 018X revenue code would reflect 26 units.

Example #3-B:

In Example #3A above, the occurrence span code 74 would show a from date of 10/10/02 and a through date of 11/22/02. The 018X revenue code would reflect 44 units.

Interrupted Stay of One Day

There may be situations where a patient is discharged from an LTCH and then admitted to an acute care hospital, IRF or SNF (including swing-beds), but the patient returns to the LTCH by midnight of the same day.

One-day Interruption Example

A patient is admitted to the LTCH on 11/2/02. The patient discharged from the LTCH and admitted to an acute care hospital on 11/10/02 and then returns to the LTCH by midnight on 11/10/02.

This situation meets the criteria of a one-day interrupted stay (because the day count for the interrupted stay policy starts on the date of discharge). **However, no occurrence span code 74 and no revenue code 018X are required on the UB-92.** Interrupted stays of more than one day **do** require this coding on the UB-92.

UB-92 Coding Instructions for Interrupted Stays

To bill a claim to Medicare with an interrupted stay, on the UB-92 indicate:

- The "from" date is the original date of admission
- The "through" date is the final date of discharge
- Payable days go in the covered days field
- Interruption days go in the noncovered days field
- Total days of service on the claim = payable days & interruption days & leave of absence days & noncovered level of care days & days after benefits exhaust if those days fall before the claim exceeds the short stay outlier policy or if those days fall within the high cost outlier period
- Appropriate patient status code (PSC) to show the transfer upon discharge to the acute care hospital (PSC=02), IRF (PSC=62) or SNF (PSC=03) or Swing-bed (PSC=61)
- Occurrence span code 74, for interruptions of more than one day, with the dates the patient spent at the "receiving" provider
- "From date" is date of initial discharge from the LTCH
- "Through date" is the last date the patient is not present at midnight
- Revenue code 018X to show the number of interruption days

- Units equal the number of days reflected in Occurrence span code 74
- No code or charges in HCPCS/Rates field
- Do not list charges in covered or noncovered
- Accommodation revenue code 010X-021X
- Show daily room rate in HCPCS/Rates field
- Show total number of payable and noncovered days (do not list interruption days or LOA days as "noncovered" on this line)
- Charges must equal daily room rate multiplied by number of payable days
- Appropriate coding as required, including ancillary revenue codes and charges on the remainder of the claim

Interrupted Stay Claim Examples

The claim examples that follow show the applicable UB-92 codes to reflect interruptions for each provider type included in the interruption policy (acute care hospital, IRF, and SNF or swing-bed). The examples will show that the patients, in these cases, returned to the same LTCH by the last possible day in the interrupted stay policy. However, the LTCH would code Medicare claims for interruptions for up to and including 9 days for acute care hospitals, up to and including 27 days for IRFs and up to and including 45 days for SNFs (including swing-beds).

Claim Example #1-C – Discharge to and readmission from an acute care hospital

Patient was admitted to an LTCH, discharged from the LTCH, and admitted to an acute care hospital. The patient then returns to the LTCH within the 9-day interruption policy. The example will show the patient returned on the 9th day after discharge.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	10/05/02	12/11/02	59	8			

12 PATIENT NAME	13 PATIENT ADDRESS
Annie Acute	

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
								02									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								74	10/10/02	10/17/02	A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		100.00		59	5900	00			
018X				8					
	PLUS ANCILLARY REVENUE CODES AND CHARGES								
001	Total Charges				XXXX	XX			

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
	85 PROVIDER REPRESENTATIVE 86 DATE
Claim Example of a 9-day Interrupted stay at Acute Care Hospital	x

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

Claim Example #2-C – Discharge to and readmission from an IRF

Patient was admitted to an LTCH, discharged from the LTCH and then admitted to an IRF. The patient returns to the LTCH within the 27-day interruption policy. The example will show that the patient returned on the 27th day after discharge.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	10/05/02	12/31/02	61	26	1		

12 PATIENT NAME	13 PATIENT ADDRESS
Ronnie Rehab	

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
								62									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								74	11/30/02	12/25/02	A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		100.00		61	6100	00			
018X				26					
	PLUS ANCILLARY REVENUE CODES AND CHARGES								
001	Total Charges				XXXX	XX			

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Claim Example of 27 day Interrupted Stay at IRF	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

Claim Example #3-C – Discharge to and Readmission from a SNF

Patient was admitted to an LTCH and then discharged. Upon discharge from the LTCH, the patient is admitted to a SNF and returns to the LTCH within the 45-day interruption policy. The example will show that the patient returned on the 45th day after discharge.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	10/05/02	12/11/02	23	44			

12 PATIENT NAME	13 PATIENT ADDRESS
Suzie Skilled	

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
								03									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								74	10/10/02	11/22/02	A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		100.00		23	2300	00			
018X				44					
	PLUS ANCILLARY REVENUE CODES AND CHARGES								
001	Total Charges				XXXX	XX			

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Claim Example of 45 day Interrupted Stay at SNF	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

Patient Classification

Certain data elements on the claim determine the patient classification system grouping into which the claim will fall. The patient classification system groupings are called LTC-DRGs.

Claims submitted for processing to the FI are subject to series of edits called Medicare Code Editor (MCE), which is designed to identify cases that would require further review before classification into a LTC-DRG. After screening by the MCE, each claim is classified into the appropriate LTC-DRG by the Medicare LTCH GROUPER. The LTCH GROUPER is specialized computer software based on the GROUPER utilized by the acute care hospital inpatient prospective payment system. Following the LTC-DRG assignment, the FI determines the prospective payment by using the Medicare PRICER program, which accounts for hospital-specific adjustments.

An LTC-DRG is selected from certain information that LTCHs report on the Medicare claim. The information on the Medicare claim must be as accurate and complete as possible, particularly since the Medicare payment is based on the following factors:

- Principle diagnosis
- Up to eight additional diagnoses
- Up to six procedures performed
- Age of the patient
- Sex of the patient
- Discharge status of the patient

Diagnosis and Procedure Codes

The use of diagnosis and procedure codes is not a new billing requirement. And, the placement of accurate diagnosis and procedure codes in the appropriate field locators within the UB-92 claim form is still required.

However, these two types of codes, along with other factors, ultimately determine the LTC-DRG for the claim. Appropriate payment is dependent upon the accuracy of the diagnosis and procedure codes on the claim.

Changes to Processed LTC-DRGs

LTCHs will have the opportunity to review the LTC-DRG assignments made by the FI. An LTCH will have 60 days after the date of the notice of the initial assignment of a discharge to an LTC-DRG (date of the LTCH's Medicare remittance) to request a review of that assignment. Following this 60-day period, the LTCH would not be able to submit additional information with respect to the LTC-DRG assignment or otherwise revise its claim.

The LTCH will be allowed to submit additional information as part of its request. The FI will review that LTCH's request and any additional information and would decide whether a change in the LTC-DRG assignment is appropriate.

If the FI decides that a different LTC-DRG should be assigned, the FI will refer the claim to the appropriate QIO to review the case.

Furnishing of Inpatient Hospital Services Directly or Under Arrangements

In accordance with existing regulations and for consistency with other established hospital prospective payment systems policies, an LTCH must furnish covered services to Medicare beneficiaries either directly or under arrangements.

The LTCH prospective payment will be payment in full for all covered inpatient hospital services. Medicare will not pay any provider or supplier other than the LTCH for services furnished to a Medicare beneficiary who is an inpatient of the LTCH, except for the following services, which should be billed to the appropriate Medicare Carrier:

Physicians' services

Physician assistance services

Nurse practitioners and clinical nurse specialist services

Certified nurse midwife services

Qualified psychologist services

Services of an anesthetist

Benefits Exhausted During Stay

Under regular inpatient hospital PPS, if benefits exhaust during the stay, the PPS provider will still be paid the full basic prospective payment. That is, if a beneficiary has one benefit day available, the hospital is paid the full basic DRG. When acute care hospitals bill Medicare, they do not reflect medically necessary days after benefits exhaust as noncovered.

Under LTCH PPS, if benefits exhaust during the stay before the claim exceeds the short stay outlier criteria, the LTCH will be paid a short stay outlier payment. When the LTCHs bill Medicare in this case, they should reflect medically necessary days in the covered field and medically unnecessary days in the noncovered field.

The FI will determine the date on which benefits are exhausted and apply the appropriate benefits exhaust code (A3), the date benefits exhausted, as well as determine the appropriate benefit application. **Ultimately, the days after benefits exhaust in this case would be noncovered.**

However, if benefits exhaust during the stay but after the claim exceeds the Short-stay Outlier criteria, the LTCH provider will be paid the full LTC-DRG payment.

Benefits Exhaust After Short Stay Outlier Threshold is Exceeded

Once the claim exceeds the short stay outlier criteria, inpatient prospective payment billing rules apply. In other words, if the beneficiary still had regular benefit days available once the short stay outlier criteria threshold was exceeded, these regular benefit days would continue to be applied toward the remaining days within the stay until they exhaust.

In addition, if the regular benefit days exhaust before any applicable high cost outlier threshold is reached, the days between the day the regular benefits exhaust and the day after the day the high cost outlier threshold is reached are considered to be paid but "non-utilized". As long as the patient did not need to use any available LTR days to exceed the short stay outlier threshold, he/she may retain those LTR days to use within any applicable high cost outlier period. This policy can extend the date on which the patient's benefits actually exhaust.

When the LTCHs bill Medicare in this case, as with the case of a short stay outlier, they should reflect medically necessary days in the covered field and medically unnecessary days in the noncovered field. However, upon processing the claim for payment, the FI will determine the date on which benefits are exhausted and apply the appropriate benefits exhaust code (A3), the date benefits exhausted, the span code 70 representing non-utilized days as described above and the appropriate benefit application.

If necessary, the claim will be returned to the provider with an explanation of the appropriate benefit application and coding and request any additional changes to the claim required by the LTCH.

Note:

In both of these cases, the FI also determines the number of cost report days, which are the number of days for which Medicare is actually making payment, not the number of days utilized by the beneficiary. These days include non-utilization days (days within the 70 span code).

Coding Benefits Exhaust During the Stay

For LTCHs, under LTCH PPS, to bill a claim where benefits exhaust during the stay, they should use the following instructions:

Use type of bill 11X.

Report covered and noncovered days as usual.

Report the accommodation revenue code(s) and ancillary charges with their respective covered and noncovered units and charges

Remainder of claim is coded using existing requirements

The next several pages contain five benefits exhausted claim examples as they would appear after the initial FI processing. The first two are examples of claims that meet the short stay outlier criteria (and payable a short stay outlier) where the patients have exhausted benefits. The next three examples are of claims that exceed the short stay outlier criteria (and paid the regular LTC-DRG) where the patient has exhausted benefits. In these three examples, it is assumed that:

1. The high cost outlier threshold amount is $50,000 (although none of these examples have a high cost outlier that is payable)

2. The threshold amount is reached on the 25th day

3. The DRG average length of stay (ALOS) equals 12 days, therefore, the short stay outlier threshold equals 10 days

4. The billed charges are $3,000 per day for the first 12 days, $2,000 on the 13th day and $1,000 each day thereafter

5. Beneficiary elects to use any available LTR days

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	9	21	9	0	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 1-b	Benefits Available at Admit = 9 co and 0 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
A3	01/09/03										A
											B
											C

38	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a					
	b					
	c					
	d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	4500	00	10500	00	
	PLUS ANCILLARY REVENUE CODES AND CHARGES				22500	00	17500		
001	Total Charges				27000		28000	00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Short Stay Outlier	85 PROVIDER REPRESENTATIVE X — 86 DATE

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	9	21	0	9	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 4	Benefits Available at Admit = 9 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
A3	01/09/03										A
											B
											C

38	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
						a
						b
						c
						d

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	4500	00	10500	00	
	PLUS ANCILLARY REVENUE CODES AND CHARGES				22500	00	17500	00	
001	Total Charges				27000	00	28000	00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Short Stay Outlier Cost Report Days = 9	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	19	11	9	10	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 1-c	Benefits Available at Admit = 9 co and 10 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
A3	01/25/03	47	01/26/03					70	01/20/03	01/25/03	A
											B
											C

38	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a					
	b					
	c					
	d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	12500	00	2500	00	
	PLUS ANCILLARY REVENUE CODES AND CHARGES				40000	00	2500	00	
001	Total Charges				37500	00	5000	00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Full LTC-DRG Cost Report Days = 25	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	15	15	15	0	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 2-c	Benefits Available at Admit = 15 co and 0 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
A3	01/25/03	47	01/26/03					70	01/16/03	01/25/03	A
											B
											C

38	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	A					
	b					
	C					
	d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	12500	00	2500	00	
	PLUS ANCILLARY REVENUE CODES AND CHARGES				37500	00	2500	00	
001	Total Charges				50000	00	5000	00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Full LTC-DRG Cost Report Days = 25	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	12	18	0	12	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 5-a	Benefits Available at Admit = 12 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
A3	01/25/03	47	01/26/03					70	01/13/03	01/25/03	A
											B
											C

38	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	A					
	b					
	C					
	d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	12500	00	2500	00	
	PLUS ANCILLARY REVENUE CODES AND CHARGES				37500		2500	00	
001	Total Charges				50000	00	5000	00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Full LTC-DRG Cost Report Days = 25	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

High Cost Outliers

Under LTCH PPS, additional payments will be made for those cases that are high cost outliers. These are cases that are classifiable into a specific LTC-DRG, but also have an exceptionally high cost relative to the cost of most discharges.

The high cost outlier payment applies only after accumulated covered charges reach the high cost outlier threshold amount. Under the LTCH PPS, the high cost outlier threshold amount is the LTC-DRG payment plus a fixed-loss amount. The fixed-loss amount for fiscal year 2003 is $29,852.00.

High cost outlier payments apply to days within the "outlier period".

The outlier period is a period of time that begins on the day after the day the provider's accumulated charges reach the cost outlier threshold.

If a patient's benefits exhaust before the cost outlier threshold is reached, a high cost outlier payment will **not** be made. If a patient's benefits exhaust after the cost outlier threshold is reached, a high cost outlier payment will **apply only to medically necessary days for which the patient has benefits available**.

Upon receipt of a claim, the FI will determine an appropriate additional payment for inpatient services where the provider's charges for covered services furnished to the beneficiary, adjusted for cost, are inordinately high. The FI makes cost outlier determinations and pays any outlier amount indicated by its PRICER program **unless the provider indicates a condition code 66.**

The provider should submit the claim as usual, with covered and noncovered days and charges including the applicable noncovered span codes of 74, 76 and 79.

If the beneficiary exhausted benefits during the stay, then the LTCH should follow the instructions as noted in the "benefits exhaust" section previously discussed.

If there are enough benefit days for each medically necessary day in the outlier period, the LTCH will not receive the claim for correction and the FI's PRICER program will calculate the appropriate payment including the high cost outlier payment.

If there are not enough benefit days for each medically necessary day in the outlier period, the FI will **return** the claim to the LTCH. The FI's system will instruct the provider of the high cost outlier threshold amount.

The provider then adds the daily covered charges for the claim, determines the day that covered charges reach the outlier threshold amount and places a 47 occurrence code on the claim with the day after the day the cost outlier threshold was reached. The provider must also enter noncovered days and charges on the claim for the days after occurrence code 47 when benefit days exhaust prior to or within the cost outlier period.

Benefits Exhausted with Payable High Cost Outlier

The following two pages contain two benefits exhausted claim examples with payable high cost outliers as they would appear after FI processing.

Examples' Assumptions

1. The high cost outlier threshold amount is $50,000
2. The threshold amount is reached on the 25th day
3. The DRG average length of stay (ALOS) equals 12 days, therefore, the short stay outlier threshold equals 10 days
4. Billed charges are $3,000 per day for the first 12 days, $2,000 on the 13th day and $1,000 each day thereafter
5. Beneficiary elects to use any available LTR days

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	18	12	15	3	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 2-b	

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
A3	01/28/03	47	01/26/03					70	01/16/03	01/25/03	A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	A						
	b						
	C						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	14000	00	1000	00	
	PLUS ANCILLARY REVENUE CODES AND CHARGES				39000	00	1000	00	
001	Total Charges				53000	00	2000	00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Full LTC-DRG plus high cost outlier based on $53,000 covered charges Cost Report Days = 28	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	28	2	0	28	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 5-c	Benefits Available at Admit = 28 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
A3	01/28/03	47	01/26/03								A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	A						
	b						
	C						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	14000	00	1000	00	
	PLUS ANCILLARY REVENUE CODES AND CHARGES				39000	00	1000	00	
001	Total Charges				53000	00	2000	00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Full LTC-DRG plus high cost outlier based on $53,000 covered charges Cost Report Days = 28	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

Benefits Not Exhausted with Payable High Cost Outlier

The next three pages are examples, with the same assumptions as the previous three, with **payable** high cost outliers, but **benefits are not exhausted** in these cases:

Examples' Assumptions

1. The high cost outlier threshold amount is $50,000
2. The threshold amount is reached on the 25th day
3. The DRG average length of stay (ALOS) equals 12 days, therefore, the short stay outlier threshold equals 10 days
4. Billed charges are $3,000 per day for the first 12 days, $2,000 on the 13th day and $1,000 each day thereafter
5. Beneficiary elects to use any available LTR days

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	30	0	9	21	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 1-a	Benefits Available at Admit = 9 co and 60 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	15000	00			
	PLUS ANCILLARY REVENUE CODES AND CHARGES				40000	00			
001	Total Charges				55000	00			

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Full LTC-DRG plus cost outlier based on $55,000 covered charges Cost Report Days = 30	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	20	10	15	5	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 2-a	Benefits Available at Admit = 15 co and 60 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
47	01/26/03							70	01/16/03	01/25/03	A
											B
											C

38	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a					
	b					
	c					
	d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	15000	00			
	PLUS ANCILLARY REVENUE CODES AND CHARGES				40000	00			
001	Total Charges				55000	00			

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Full LTC-DRG plus high cost outlier based on $55,000 covered charges Cost Report Days = 30	85 PROVIDER REPRESENTATIVE X 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/31/03	30	0	0	30	

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 5b	Benefits Available at Admit = 60 LTR

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	A						
	b						
	C						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		30	15000	00			
	PLUS ANCILLARY REVENUE CODES AND CHARGES				40000	00			
001	Total Charges				55000	00			

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
Full LTC-DRG plus cost outlier based on $55000 covered charges Cost Report Days = 30	85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

Benefits Exhaust Prior to Admission and Other No-Payment Bills

When a patient does not have any benefits remaining in his/her benefit period and he/she is at a Medicare covered level of care, a claim needs to be submitted to Medicare in order to properly document the continuation of the benefit period.

To bill a claim where Medicare benefits exhaust prior to the stay:

Use TOB 11X

Report all noncovered days

Report any services that cannot be billed under the Part B benefit using 12X TOB

Providers must continue to submit bills for all stays, including those for which no Medicare payment can be made. This assists the FI and CMS in maintaining utilization records and determining remaining eligibility. Even though these bills are noncovered, a bill is required because hospitalization could extend a benefit period.

Hospitals on PPS submit a single bill for a beneficiary's entire stay where no Medicare payment is being made. Therefore, LTCHs on LTCH PPS must be in accordance with the same requirement. The bill is submitted to the FI upon the patient's discharge or death. The provider is not required to send a no-payment discharge bill where the beneficiary is entitled only to Medicare Part B.

Reference:

To view a list of the situations for which no-payment bills are required, providers may refer to the CMS Hospital Manual, Pub.10, Section 411 or Pub. 13, Section 3624. This includes Medicare Secondary Payer (MSP) situations, where the LTCH has received full payment from the primary payer (or an amount considered to be full payment under contractual arrangement or law) and no payment is due from Medicare.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Long Term Care Hospital (LTCH)			111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/03	01/21/03	0	20			

12 PATIENT NAME	13 PATIENT ADDRESS
Patient # 3 with No-Pay Codes	Benefits Available at Admit = 0

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
							A
							b
							C
							d

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
012X		500.00		20	15000	00	15000	00	
	PLUS ANCILLARY REVENUE CODES AND CHARGES THAT CANNOT BE BILLED UNDER THE PART B BENEFIT				30000	00	30000	00	
001	Total Charges				45000	00	45000	00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57	DUE FROM PATIENT ☐

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
12345											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
No Payment Bill Cost Report Days = 0	85 PROVIDER REPRESENTATIVE 86 DATE X

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.